



AUTISM FUNDING PROOF OF SERVICE

FAX: 519-972-8902

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

PARENT'S NAME: _____

CHILD'S NAME: _____

RESPIRE PROVIDER'S NAME: _____

FAMILY COORDINATOR: _____

PAY PERIOD END DATE _____

****TIMESHEETS ARE DUE EVERY OTHER WEDNESDAY BY 4:00PM****

				FOR OFFICE USE ONLY	
DATE	# HOURS PROVIDED	INITIALED BY RESPITE PROVIDER	ACTIVITIES	RATE	SVC TYPE
Sun					
Mon					
Tues					
Wed					
Thur					
Fri					
Sat					
Sun					
Mon					
Tues					
Wed					
Thur					
Fri					
Sat					
TOTAL HOURS:					
OTHER SERVICE PROVIDED Please attach receipts		Description:		\$	
				TOTAL:	\$

I verify that these services were provided for me. I have been authorized by Family Respite Services to use these services. I am invoicing FRS for the funds which I have paid to my respite provider/caregiver.

Signature of Parent/ Guardian: _____ Date: _____

Signature of Respite Provider: _____ Date: _____